

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-027289 ✓

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3728

STATE FILE NUMBER

FILED JUL 30 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>		a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in lb <b>22 YEARS</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL, K.C., MO</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5716 MYRTLE AVENUE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
<b>CLEO FRANKLIN PATTON</b>			<b>JULY 14, 1962</b>		

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-18-19</b>	9. AGE (last birthday) <b>42 43</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATIONARY FIREMAN</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>KANSAS CITY SCHOOL DISTRICT</b>	11. BIRTHPLACE (City and state or country) <b>SYRACUSE, KANSAS</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>ENNIS PATTON</b>	13b. MOTHER'S MAIDEN NAME <b>MINNIE MAE PIPPINGER</b>	14. NAME OF HUSBAND OR WIFE <b>IMOGENE D. PATTON</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW II</b>	16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	17. INFORMANT <b>OFFICIAL RECORDS VA HOSPITAL</b>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>ENCEPH ALOMALACIA, RIGHT CEREBRAL HEMISPHERE</b>		
DUE TO (b) <b>OCCCLUSION OF RIGHT MIDDLE CEREBRAL ARTERY</b>		
DUE TO (c) <b>POST OPERATIVE STATUS FOR RIGHT MIDDLE CEREBRAL ANEURYSM</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour: _____ a.m. _____ p.m. _____	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>VA</b>	20f. CITY, TOWN, OR LOCATION <b>VA Hospital, K.C., Mo.</b>	COUNTY	STATE
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21. Attended the deceased from **7-9-62** to **7-14-62**  
Death occurred at **10:15** p. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>R. H. Owings M.D.</i> (Degree or title)	22b. ADDRESS <b>VA Hospital, K.C., Mo.</b>	22c. DATE SIGNED <b>7-15-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>JULY 17, 62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SENECA CEMETERY</b>	23d. LOCATION (City, town, or county) <b>SENECA MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>	ADDRESS <b>1331 BRUSH CR. KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>7-17-62</b>	26. REGISTRAR'S SIGNATURE <i>Kath H Long</i>
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(Licensed Embalmer's Statement on Reverse Side)

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

R. H. Owings M.D.

MEDICAL CERTIFICATION

DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harold P. Reich

Licensed Embalmer No. 1998

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.